

CERTIFICATE OF DEATH

Reg. Dist. No.

51

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | | | |
|---|----------------------------|--|----------------------------------|---|-----------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Calvert</i> | | MARYLAND | | STATE <i>Va</i> | | COUNTY <i>Fairfax</i> | |
| CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>St Leonard</i> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Vienna</i> | | 83X-3 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <i>Leville David Ashworth</i> | | | | DEATH: <i>4-17</i> 19 <i>55</i> | | | |
| 5. SEX: <i>M</i> | 6. COLOR OR RACE: <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>M</i> | 8. DATE OF BIRTH: <i>3-12-23</i> | 9. AGE last birthday <i>32</i> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <i> Clerk</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: <i>Acme Food Store</i> | | 11. BIRTHPLACE (State or foreign country): <i>Mc Bee Co., Va.</i> | |
| 13. FATHER'S NAME: <i>Ezra Ashworth</i> | | | | 14. MOTHER'S MAIDEN NAME: <i>Edith Redden</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>233-30-8125</i> | | 17. INFORMANT & ADDRESS: <i>Selective Service Registrations Card</i> | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <i>Drowned</i> | | | | | | | |
| ANTECEDENT CAUSE (S) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Body washed ashore 4/26/55</i> | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) <i>Bay - Long Beach</i> | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>Long Beach Calvert Md</i> | |
| 21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY <i>4-17-55 12:30 P.M.</i> | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work | | 21F. HOW DID INJURY OCCUR? <i>Boat over turned</i> | |
| 22. I hereby certify that I attended the deceased from <i>1955</i> , to <i>1955</i> , that I last saw the deceased alive on <i>4-17-55</i> , and that death occurred at <i>St Leonard, Md.</i> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>H. W. Ward</i> | | | | DATE SIGNED <i>4/26/55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>4-27-55</i> | | NAME OF CEMETERY OR CREMATORY <i>National Mem. Park</i> | | LOCATION (City, town, or county) (State) <i>Fairfax Church, Va.</i> | |
| DATE REC'D BY LOCAL REGISTRAR <i>4-26-55</i> | | REGISTRAR'S SIGNATURE <i>H. W. Ward</i> | | 24. FUNERAL DIRECTOR <i>Money & King</i> | | ADDRESS <i>Vienna, Va.</i> | |

BUREAU V. B.

APR 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3508

CERTIFICATE OF DEATH

Reg. Dist. No. 52 03498

| | | | | | | | |
|--|----------------------------|--|--|--|-----------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Calvert</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>Anne Arundel</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town): | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | 02X-2 | |
| X TOWN <u>Prince Frederick, md.</u> | | <u>5 days</u> | | STREET ADDRESS | | (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u> | | | | | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>Charles Hamilton Birchhead</u> | | | | OF DEATH: <u>April</u> <u>13</u> <u>1955</u> | | | |
| 5. SEX: <u>m</u> | 6. COLOR OR RACE: <u>w</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>w. Dowel</u> | 8. DATE OF BIRTH: <u>July 11, 1867</u> | 9. AGE last birthday <u>87</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farming</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Owner</u> | | 11. BIRTHPLACE (State or foreign country): <u>Calvert Co md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME: <u>Robert Birchhead</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Eleanor Stallings</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: <u>Mrs. Helen Dvorings Dvorings md</u> | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u> DUE TO <u>5 yrs</u> | | | | | | | |
| ANTECEDENT CAUSE (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/2</u> , 19 <u>48</u> , to <u>4/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>55</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>H. H. H. H.</u> | | M. D. <u>Dvorings</u> | | DATE SIGNED <u>Med 4/14/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/16/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Friendship md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>April 16, 1955</u> | | REGISTRAR'S SIGNATURE <u>Dean F. Hutchins</u> | | 24. FUNERAL DIRECTOR <u>Wm H. Hutchins</u> | | ADDRESS <u>Dvorings md</u> | |

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

ADMINISTRATIVE AND FINANCIAL

BUREAU V. S.

APR 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03497
Reg. Dist.

No. 51

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Calvert</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>Calvert</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Princess Anne</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Lusby</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH | |
| (First) <u>James</u> | (Middle) <u>Edmond</u> | (Last) <u>Culley</u> | (Month) <u>4</u> (Day) <u>15</u> (Year) <u>1955</u> |
| 5. SEX: <u>MA</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: <u>Dec 28</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Fabricator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: | 9. AGE last birthday: <u>56</u> yrs. |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Henry Culley</u> | | 14. MOTHER'S MAIDEN NAME: <u>Alverla Johnson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>yes</u> | | 16. SOCIAL SECURITY No.: <u>217-05-7863</u> | |
| (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS: <u>Amos Johnson Lusby, Md.</u> | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH |
| 420.1 Immediate cause (a) <u>Crowning disease and</u> DUE TO Antecedent cause(s) (b) <u>Hypertensive Heart Disease</u> Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>was unwell & fell in his wheel chair</u> | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) | (County) |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE <u>Howard D. M. 2</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/15/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| | <u>4-19-55</u> | <u>St Johns</u> | <u>Lusby, Md</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS | |
| <u>4-18-55</u> | <u>N.W. Ward</u> | <u>P.E. Sewell Printer Fred, Md.</u> | |

RECEIVED

APR 19 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03498
3510 CERTIFICATE OF DEATH

Reg. Dist. No. 51

| | | | | | | | |
|---|-------------------|---|---------------------|---|------------------|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Cabaret</u> | | MARYLAND | | STATE <u>Ind</u> | | COUNTY <u>Cabaret</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| <u>X</u> <u>Solomons</u> | | <u>35 yrs</u> | | <u>Solomons</u> <u>X</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>00</u> | | | | | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| (First) <u>Helen</u> (Middle) <u>Clearance</u> (Last) <u>Sloney</u> | | | | <u>Apr. 29</u> , 19 <u>55</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | | IF UNDER 1 YEAR | |
| <u>F</u> | <u>W</u> | <u>M</u> | <u>May 12, 1902</u> | <u>52</u> yrs. | <u>11</u> Months | <u>17</u> Days | IF UNDER 24 HRS. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Housewife</u> | | <u>Home</u> | | <u>Baltimore, Ind</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Charles McDonald</u> | | | | <u>P. Curtin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| <u>No</u> | | | | <u>No</u> | | <u>Thomas Sloney - Solomons, Ind</u> | |
| 15. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 IMMEDIATE CAUSE | | | | | | | |
| (A) DUE TO <u>Cornary thrombosis</u> | | | | | | | |
| ANTECEDENT CAUSE (S) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (B) DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| | | | | | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>April 29</u> , 19 <u>55</u> , to <u>April 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 29</u> , 19 <u>55</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u> | | | | | | | |
| SIGNATURE <u>Helen Clearnce Sloney</u> | | | | DATE SIGNED <u>4/30</u> | | | |
| | | | | M. D. <u>50 Leomar</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>May 1, 1955</u> | | <u>Middleham Chapel</u> | | <u>Lundy - Cabaret Co - Ind</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>4/30/55</u> | | <u>H. W. Ward</u> | | <u>A. A. Harkness & Son - Ind.</u> | | <u>Ind.</u> | |

BUREAU V. S.

MAY 4 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03499

3511

CERTIFICATE OF DEATH

Reg. Dist. No. 51

| | | | | | | | |
|--|--------------------------------|--|---|--|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Calvert</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Calvert</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>0 Pa. Frederick</u> | | LENGTH OF STAY (in this place) <u>16 1/2 hrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Island Creek</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>64 Calvert County Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>Benjamin F. Fowler</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>April 4 1955</u> | | | |
| 5. SEX: <u>m</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MAR</u> | 8. DATE OF BIRTH: <u>MARCH 25, 1870</u> | 9. AGE last birthday: <u>85</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country): <u>Calvert County, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME: <u>Benjamin Fowler</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Eliza Essey</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO.: <u>No</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Lester Hall, Island Creek, MD</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>442X</u> | | | | | | | |
| ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (A) <u>Cardio vascular renal disease</u> | | | | | | <u>5 yr</u> | |
| (B) _____ | | | | | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? | | (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8 45 A</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | M. D. <u>[Signature]</u> | | DATE SIGNED <u>4/4/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Apr. 6, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u> | | LOCATION (City, town, or county) (State) <u>Pa. Republic, Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4-5-55</u> | | REGISTRAR'S SIGNATURE <u>A W Ward</u> | | 24. FUNERAL DIRECTOR <u>A. G. Harkness</u> | | ADDRESS <u>Don-Mutual, Ind.</u> | |

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE
WASHINGTON, D. C. 20540

BUREAU V. S.

APR 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 51

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Va</u> COUNTY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>St Michaels</u> | | | | CITY (If outside corporate limits write RURAL and give nearest town) <u>St Michaels Va</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>George G. Gentry</u> | | | | STREET ADDRESS (If rural, give location) <u>83X-3</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) (Middle) (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| <u>George Edward Gentry</u> | | | | <u>4 17</u> | | <u>19 55</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH: <u>10/28 1917</u> | 9. AGE last birthday: <u>37</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Professor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Prof</u> | | 11. BIRTHPLACE (State or foreign country): <u>Va</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Harry B. Gentry</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Claudia Stotter</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY No.: <u>13</u> | | 17. INFORMANT & ADDRESS: <u>Frances Gentry</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Drowned</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Boat capsized</u> | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | | 21c. (City or town) (County) (State) | | | |
| <u>Boat</u> | | <u>St Michaels</u> | | <u>Calvert</u> | | <u>Va</u> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4/17/55 1230 P.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Boat turned over</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>H. W. Ward</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. <u>4/17/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u> | | DATE THEREOF <u>4/20/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt. Comfort</u> | | LOCATION (City, town, or county) (State) <u>Alexandria, Va</u> | |
| DATE REC'D BY LOCAL REG. <u>4/18/55</u> | | REGISTRAR'S SIGNATURE <u>H. W. Ward</u> | | 24. FUNERAL DIRECTOR <u>A. A. Harkness & Son - Mutual, Ind</u> | | | |

3512

03500

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

| | | | |
|-----------------------|----------------------|-----------|----------|
| NAME | LAST | FIRST | MIDDLE |
| DATE OF BIRTH | PLACE OF BIRTH | CITY | STATE |
| EDUCATION | EMPLOYMENT | RESIDENCE | RELIGION |
| POLITICAL AFFILIATION | CHARACTER OF SERVICE | REMARKS | |

RECEIVED
APR 19 1965
BUREAU V. S.

MARYLAND

03501
STATE DEPARTMENT OF HEALTH

3513

CERTIFICATE OF DEATH

Reg. Dist. No. 51

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Calvert</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Adelina</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Adelina</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> | | STREET ADDRESS (If rural, give location) <u>1</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>James</u> | (Middle) <u>Denny</u> | (Last) <u>Gross</u> |
| 4. DATE OF DEATH | (Month) <u>4</u> | (Day) <u>8</u> | (Year) <u>1955</u> |
| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>June 15</u> |
| 9. AGE last birthday <u>80</u> yrs. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 13. FATHER'S NAME <u>Geo. Gross</u> | 14. MOTHER'S MAIDEN NAME <u>Jane Wilson</u> | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) |
| 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS <u>Wilson Gross, Adelina md.</u> | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|---|---|-----------------------|----------|---------|
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Nov, 1954, to April 8, 1955, that I last saw the deceasedalive on March 10, 1955, and that death occurred at 4:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|---|---|---|-------------------|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE <u>4-10-55</u> | NAME OF CEMETERY OR CREMATORY <u>Carrolls</u> | LOCATION (City, town, or county) <u>Barstow</u> | (State) <u>md</u> |
| DATE REC'D BY LOCAL REG. <u>4-9-55</u> | REGISTRAR'S SIGNATURE <u>H. W. Ward</u> | 24. FUNERAL DIRECTOR <u>P. E. Sewell</u> | ADDRESS <u>Prince Frederick, md.</u> | |

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 13 1955

RECEIVED

3514

CERTIFICATE OF DEATH

Reg. Dist. No. 51

| | | | | | | | |
|---|----------------------------|--|--------------------------------------|---|------------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Calvert</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Calvert</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>De Frederick,</u> | | <u>1 hr</u> | | OR TOWN <u>North Beach</u> X | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <u>Russell</u> <u>Grund</u> | | | | OF DEATH: <u>4</u> <u>27</u> 19 <u>55</u> | | | |
| 5. SEX: <u>m</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MAR.</u> | 8. DATE OF BIRTH: <u>Nov 1, 1890</u> | 9. AGE last birthday: <u>64</u> yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME: <u>David Grund</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Freda Connelly</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: <u>Mrs. Mildred Grund, North Beach, MD</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 181X IMMEDIATE CAUSE (A) <u>Carcinoma of bladder</u> | | | | | | | |
| ANTECEDENT CAUSE (S) DUE TO (B) | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>4/25</u> , 19 <u>55</u> , to <u>4/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>55</u> , and that death occurred at <u>8:10 AM</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>H. Weems</u> | | ADDRESS <u>M. D. Huntingtown Rd</u> | | DATE SIGNED <u>4/27/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/30/1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | LOCATION (City, town, or county) (State) <u>Smithland, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4-27-55</u> | | REGISTRAR'S SIGNATURE <u>A. W. Ward</u> | | 24. FUNERAL DIRECTOR <u>J. Wm Lee Sons Co - Wash., D.C.</u> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1955

RECEIVED

3515

CERTIFICATE OF DEATH

Reg. Dist. No. 57

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>Calvert</i> | MARYLAND | STATE <i>MD</i> | COUNTY <i>Calvert</i> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <i>The Frederick, MD</i> | LENGTH OF STAY (in this place) <i>3 days</i> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Dowell, MD</i> | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i> | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH: | |
| (First) <i>Boyd</i> | (Middle) <i>Jefferson</i> | (Last) | (Month) <i>4</i> (Day) <i>25</i> (Year) <i>1955</i> |
| 5. SEX: <i>M</i> | 6. COLOR OR RACE: <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>MAR</i> | 8. DATE OF BIRTH: <i>JAN. 26 1908</i> |
| 9. AGE last birthday: <i>47</i> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Carpenter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY: | |
| 11. BIRTHPLACE (State or foreign country): <i>Lusby, MD</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>US</i> | |
| 13. FATHER'S NAME: <i>William Jefferson</i> | | 14. MOTHER'S MAIDEN NAME: <i>Martha Hutchins</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>unk</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS: <i>Thelma Jefferson, Dowell, MD</i> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 601X IMMEDIATE CAUSE | | | |
| ANTECEDENT CAUSE (S) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>4/22</i> , 19 <i>55</i> , to <i>4/25</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/24</i> , 19 <i>55</i> , and that death occurred at <i>3:25 P.</i> M. from the causes and on the date stated above. | | | |
| SIGNATURE <i>Robert Williams</i> | | DATE SIGNED <i>4/27</i> | |
| M. D. <i>St. Thomas</i> | | | |
| 23. (BURIAL, CREMATION, REMOVAL (SPECIFY)) | | DATE THEREOF | |
| NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>4, 28, 55</i> | | <i>St. John's</i> | |
| DATE REC'D BY LOCAL REGISTRAR | | 24. FUNERAL DIRECTOR | |
| <i>4-26-55</i> | | ADDRESS | |
| REGISTRAR'S SIGNATURE <i>N.W. Ward</i> | | <i>P.E. Sewell Jr. Fred, MD</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 23 1955

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

3516

CERTIFICATE OF DEATH

Reg. Dist. No. 03504 51

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Calvert</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> | |
| TOWN <u>Lusby</u> | | TOWN <u>Lusby</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) <u>1</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>East-</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>4-18, 1955</u> | |
| 5. SEX <u>m</u> | | 6. COLOR OR RACE <u>C</u> | |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH <u>Aug 2nd</u> | |
| 9. AGE last birthday <u>77</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water man</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Ashbury Polk</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Hall</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT AND ADDRESS <u>Ernest Polk, Lusby, Md.</u> | | | |

| | | |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| <p>450.0</p> <p>Immediate cause (a) <u>Heart failure -</u></p> <p>Antecedent cause(s) (b) <u>- Scurvy, Arteriosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p> | | |
| II. OTHER SIGNIFICANT CONDITIONS | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | |

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from April 5, 1955, to April 18, 1955, that I last saw the deceased alive on April 18, 1955, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE Edw. E. Ward M.D. ADDRESS St. Leonard, Md. DATE SIGNED 4/20/55

| | | | | | | | |
|---|--|-----------------------|--|-------------------------------|--|--|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) | | DATE | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| 4-21-55 | | 4-21-55 | | Eastern Chapel | | Lusby, Md. | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| 4-21-55 | | N.W. Ward | | P.E. Sewell | | Prince Fred, Md. | |

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 22 1955

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